

FIRST STEPS TRANSITION MEETING MINUTES



Date: _____

Child's Name: _____ DOB: _____

Purpose of Meeting:

___ 90-180 day Transition Meeting out of First Steps ___ Other transition within First Steps

Transition Meeting Participants:

Printed Name	Role	Phone	Signature	Time In	Time Out	Total Time
	Parent*					
	Parent*					
	Service Coord.					
	LEA Rep.					
	Head Start					

*By signing this form, parent acknowledges the Service Coordinator has reviewed Rights and Procedural Safeguards.

Child's First Steps services are anticipated to end: _____

Child's new program/services are anticipated to start: _____

Discussion Notes: (topics to include: procedural safeguards, eligibility, service coordination role, extent to which various placement options and services are appropriate, family priorities and concerns, discussion of the child's present levels of development that will affect future placement decisions, procedures to prepare the child for changes in service delivery in a new setting, recommendations by the multidisciplinary team of activities necessary to support the transition of the child)

More Information Needed/Next Steps:

Recorded by: _____ Role: _____

FIRST STEPS TRANSITION MEETING MINUTES continued

Date: _____

Child's Name: _____ DOB: _____



Discussion Notes continued:

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More Information Needed/Next Steps continued:

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Recorded by: _____ Role: _____